HEALTH PROFESSIONS

FY 2001 Performance Plan, Revised Final FY 2000 Plan and FY 1999 Performance Report

The mission of the Bureau of Health Professions (BHPr) is to contribute to ensuring access to quality health care for all Americans by supporting education and training programs that improve the diversity, distribution, and quality of the health care workforce. Through a collection of programs and activities, the Bureau strives to improve the health status of all Americans, particularly the underserved, by enhancing the education, utilization, training, diversity, and quality of the Nation's health personnel.

Through Titles VII and VIII programs, the Bureau provides both policy leadership and support for health professions workforce enhancement and educational infrastructure development. Current emphasis is on improving the geographic distribution and diversity of the health professions workforce. The Bureau utilizes an outcome-based performance system to measure whether program support is meeting its national health workforce objectives, and to signal where program course correction is necessary.

Programs included in this section include:

2.17 Health Professions and Nursing Training Programs
2.18 Workforce Information and Analysis
2.19 Children's Hospital Graduate Medical Education
2.20 Health Education and Assistance Loans (HEAL)
2.21 National Practitioner Data Bank,
Healthcare Integrity and Protection Data Bank
2.22 Vaccine Injury Compensation Program
2.23 Ricky Ray Hemophilia Relief Fund Program

2. 17 Program Title: Health Professions and Nursing Education and Training Programs

Performance Goals	Targets	Actual Performance	Refe r-ence
I. ELIMINATE BARRIERS TO CARE **A. Increase Utilization for Underserved Populations** 1. Increase the number of students/trainees in clinical training with health care service delivery organizations serving underserved areas	FY 01: 33,580 FY 00: 33,580 FY 99: 31,575	FY 01: FY 00: FY 99: 11/00 FY 98: 26,347	B137
2. Increase the number of graduates and/or program completers who enter practice in underserved areas	FY 01: 5,789 FY 00: 4,467 FY 99: 4,391	FY 01: FY 00: FY 99: 11/00 FY 98: 5,374	B137
3. Increase the number of graduates and/or program completers of health professions primary care tracks and programs that support primary care	FY 01: 46,637 FY 00: 68,232 FY 99: 68,350	FY 01: FY 00: FY 99: 11/00 FY 98: 69,786	B137
II. ELIMINATE HEALTH DISPARITIES **B. Increase Utilization for Underserved Populations** 1. Increase the number of minority/disadvantaged graduates and program completers	FY 01: 12,814 FY 00: 12,035 FY 99: 10,652	FY 01: FY 00: FY 99: 11/00 FY 98: 8,092	B137
2. Increase the number of minority/disadvantaged enrollees.	FY 01: 19,162 FY 00: 21,286 FY 99: 21,231	FY 01: FY 00: FY 99: 11/00 FY 98: 16,391	B137

Performance Goals	Targets	Actual Performance	Refe r-ence
3. Increase the number or underrepresented minorities serving as faculty	FY 01: 119 FY 00: 334 FY 99: 326	FY 01: FY 00: FY 99: 11/00 FY 98: 240	??
Total Funding: Health Professions and Nursing Training Programs ($ in 000's)	FY 2001: $217,245 FY 2000: $301,193 FY 1999: $301,177 FY 1998: $289,101	B x: page # budget HP: Healthy People goal	

2.17.1 Program Description, Context and Summary of Performance

Context:
Titles VII and VIII of the Public Health Service Act create programs to support the education and training of the healthcare workforce. The programs consist of competitive grants to organizations that train and educate healthcare professionals. Current efforts are focused on improving the geographic distribution and diversity of the healthcare workforce.

The BHPr exercises policy leadership and support for enhancing the health professions workforce and educational infrastructure. This is accomplished through administration of approximately 40 grant programs to educate and train physicians, nurses, dentists, allied health professionals and public health practitioners at approximately 1,700 institutions. BHPr personnel also maintain extensive professional relationships with numerous professional organizations concerned with health care so the programs respond quickly to evolving needs. Most grants are awarded on the basis of peer-reviewed applications to assure the highest standards of professional competence and objectivity. To assure maximum availability of information to our customers, the Bureau/Agency maintains a Web site that provides information about the Bureau/Agency, grants to be awarded in the upcoming grant cycle and materials with which to apply for a grant.

Within HRSA, the Bureau of Health Professions provides funds to the Bureau of Primary Health Care (BPHC) to support managed care fellowship activities and to Maternal and Child Health Bureau for faculty development of generalist physicians. BHPr also supports HRSA's Border Health Initiative to carry out an outreach project in four border states to train local residents as community health workers, encourage health promotion, and reach out to families

to enroll children for the Child Health Insurance Program. Finally, BHPr sponsors the revitalization of Primary Care Week through efforts of the AHEC Program, Family Medicine professional associations, student associations (AMSA) and other collaborating partners.

Program-wide performance:
The grant programs are proven successes in filling gaps left by the healthcare marketplace. For instance, while only 10% of all U.S. healthcare graduates practice in medically underserved communities, a sampling of Bureau funded programs shows 40% for Professional Nurse Traineeships, 40% for Nurse Practitioner/Midwife, and 33% for Family Practice residency practice in these areas. The goal of graduating healthcare professionals from underrepresented racial/ethnic backgrounds is similarly well-advanced by Title VII and VIII programs. Whereas the average graduating cohort of healthcare professional schools in the U.S. is composed of approximately 10% underrepresented minorities, Bureau funded programs are well targeted to achieve program objectives of graduating underrepresented minorities: 89% for the Faculty Loan Repayment Program, 50% for the Scholarships for Disadvantaged Students Program, 32% for Physician Assistant Training, 21% for Advanced Nurse Education and 19% for Preventive Medicine Residencies.

Program-level data issues:
The goals presented in Section 2.22.2 capture the significant output on Bureau goals concerning access to health care and the diversity, distribution and quality of the healthcare workforce which cut across all Title VII and VIII programs. The goals provide useful information to identify program strengths and areas that need technical assistance to better meet program objectives. The Bureau has relied on data collected from grantees, but lacked a unified approach to the collection activity. In July 1994, BHPr began developing a structured, agency-wide strategic approach to collecting performance data on Title VII and VIII health professions and nursing training and education programs. Through the assistance of outside contractors and a panel of external advisors, the agency set goals and designed a system to capture performance data. The Comprehensive Performance Management System (CPMS) is the result of this multi-year effort.

A demonstration project of the CPMS in 1998 showed that it was both feasible and desirable to capture the qualitative and quantitative information in a more streamlined manner. We also learned that designing a form that is both easy to use and sufficiently comprehensive to capture information on approximately 40 programs presents unique challenges. The first nation-wide collection of CPMS performance data from all grantees was for the period July 1, 1997 - June 30, 1998. It was completed in the Spring of 1999 and the data became available in December 1999.

Data for that year is the basis for most of the data in the FY 98 Actual Performance column on the tables presented below. The first year's data from CPMS, while confirming that the overall approach in developing the CPMS is sound, disclosed several problems in how BHPr implemented the system. As a result, the performance data shown, while mostly based on CPMS, had to be supplemented by imputing data for grantees who did not report or other estimating techniques. In some instances we used data from other sources when the reported CPMS data was obviously incorrect.

Our analysis of the problems have led the BHPr to initiate corrective action to prevent recurrence from

adversely affecting the quality of the data being collected for the performance year July 1, 1998 - June 30, 1999. Those data will be reported in the FY 99 Actual Data column in the next Annual Performance Plan. That data is expected to be available in November 2000.

We expect to have a fully automated version of the CPMS developed, tested and on line in time to begin the collection of FY 2000 data in October 2000. That automated version will further reduce the incidence of error both from grantees and data transcription and make the data that much more accurate and the collection more efficient.

2.17.2 Goal-by-Goal Presentation of Performance

Goal I. A. 1: Increase the Number of Students/trainees in Clinical Training with Health Care Service Delivery Organizations Serving Underserved Areas.

Context:
One major reason why approximately 40 million Americans do not have access to healthcare is that physicians, dentists, nurses and other health professionals are not distributed evenly throughout the population. The uneven distribution is particularly problematic in rural and inner city areas. The healthcare students funded through Title VII and VIII programs provide basic healthcare services to underserved populations as part of their training. The number of student/trainees in clinical training with health care service delivery organizations serving underserved provides an indicator of the extent to which health education programs help meet the needs of the underserved.

Performance:

	Targets			Actuals	
	FY01	FY00	FY99	FY 99 available 11/00	FY 98
Rural Interdisciplinary	1,300	1,300	1,300		1,365
HETC	280	280	275		279
AHEC	32,000	32,000	30,000		24,703
Total	**33,580**	**33,580**	**31,575**		**26,347**

Area Health Education Centers (AHECs) are exceptionally productive in terms of training health professionals in underserved areas. In FY 1998, AHECs provided about 25,000 health professions students a training experience in underserved areas. AHEC underserved training sites included 525 Community Health and Migrant Health Centers. Of the 144 U.S. medical schools, 112 participate in the AHEC program. Health Education Training Centers (HETCs) focus on training health profession students in underserved areas along the U.S. Mexico border and in Florida. In addition to training approximately 280 health professions students per year, the HETCs are training 130 local residents as community health workers. The (Quentin N. Burdick Program for) Rural Interdisciplinary Training program trains health professionals in underserved rural areas. The Rural Program slightly exceeded its goal for 1998, providing a rural interdisciplinary training experience to 1,365 health professionals.

Goal I. A. 2: Increase the Number of Graduates and/or Program Completers Who Enter Practice in Underserved Areas

Context:

There are several common strategies for encouraging graduates to enter practice in medically underserved communities (MUC). Among them are: providing didactic training to prepare students for practice in MUCs, interaction with faculty role models who serve in MUCs and placement services for practicing in such areas. In addition, studies have shown that healthcare practitioners have a higher likelihood of locating in underserved areas if they spend part of their training providing for the health needs of the underserved. Regardless of the strategy selected, one clear indicator of success for Titles VII and VIII programs is the number of graduates and/or program completers who enter practice in underserved areas.

Performance:

	Targets			Actuals	
	FY01	FY00	FY99	FY99 available 11/00	FY98
Allied Health Spcl Projects	689	1,007	922		1,164
Advanced General and Pediatric Dentistry	--	92	86		118
Health Administration	--	630	630		480
Dental Public Health	--	4	4		11
Rural Interdisciplinary	650	650	650		630
Public Health Trng Cntr (Short Term)	3,200	---	---		---
Preventive Medicine	--	11	11		11
Family Medicine - Grad Trng	--	303	312		450
Physician Asst Trng	--	406	410		527
Advanced Nurse Education	140	140	140		323
Nurse Practitioner/Midwife	230	230	230		425
Prof'l Nurse Traineeship	880	880	880		1,012
General Internal Med PED/GT	–	107	109		202
Podiatry	--	7	7		21
TOTAL	**5,789**	**4,467**	**4,391**		**5,374**

The Health Professions Training Programs are exceptionally effective in improving access for the underserved. The HRSA-supported training program targets (goals) for graduates practicing in underserved areas are 2.5 to 5.0 times higher than the National average. Programs with goals of 40% or higher include Allied Health Special Projects, Family Medicine Graduate Training, Public Health Traineeships, and the Health Administration Program. Overall, FY98 actual performance data indicate that the program goals were exceeded. In particular, FY98 performance substantially exceeded FY99 goals for: Advanced Education Nursing (the target was 35% and the actual was 52%), Nurse Practioner/Midwife (the target was 35% and the FY98 actual was 46%), Professional Nurse Traineeships (the target was 40% and the FY98 actual was 45%), and Physician Assistant Training (the target was 26% and the FY98 actual was 32%). The exceptional performance of these four programs is largely attributed to a funding strategy used whereby funding preference is given to schools with a good track record for graduates practicing in underserved areas.

FY98 actuals were significantly higher (25 percent or more) than FY99 targets for Advanced General and Pediatric Dentistry, Family Medicine Graduate Training, General Internal Medicine/Ped Graduate Training, and Podiatry.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated*

Appropriations Act of 2000, performance targets were revised to reflect the differences. These performance targets also reflect the phasing out of several Health Professions grants (i.e., Primary Care Medicine and Dentistry), because Federal efforts have demonstrated their effectiveness and are now shifted to other activities, such as improving access to care in rural and underserved communities and increasing opportunities for individuals from minority/disadvantaged backgrounds.

Goal I. A. 3: Increase the Number of Graduates and/or Program Completers of Health Professions Training Programs that Provide and Support Primary Care

Context:

Title VII and VIII education and training programs are designed to improve the geographic distribution and diversity of the health professions and nursing. The number of graduates and/or program completers provides a basis for evaluating the effectiveness of these programs in improving distribution and diversity. Performance targets were also changed to reflect changes in funding for specific program lines.

Performance:

	Targets			Actuals	
	FY01	FY00	FY99	FY 99 11/00	FY98
Long-Term Training					
Family Medicine - Fac.Dev.	--	53	53		116
Family Medicine - Grad Trg	--	759	774		859
GIM/Ped Res	--	414	423		390
GIM/GP Faculty Dev	--	101	103		44
Physician Asst Trng	--	1,561	1,595		1,254
Allied Health Spec Pro	1,378	2,014	2,050		2,050
Interdisciplinary Rural Hlth	1,300	1,300	1,300		1,448
Advanced General & Pediatric Dentistry	--	282	262		212
Public Health Traineeships	--	516	516		510
Preventive Medicine	--	31	31		41
Dental Public Health	--	15	15		11
Health Administration	--	400	400		399
Podiatry	--	20	20		60
Advanced Nurse Educ	400	400	400		497
Prof'l Nurse Traineeships	2,200	2,200	2,200		2,248
Nurse Pract/Midwife	660	660	660		923
Scholarships for Disad-vantaged Students (SDS)	3,119	3,119	3,119		2,023
Total - Long Term	**6,357**	**13,845**	**13,921**		**13,085**
Short-Term Training					
AHEC	32,000	32,000	30,000		26,859
Family Medicine/Faculty Development (Short)	--	2,034	2,079		937
GIM/GP Faculty Development (Short)	--	73	75		258
Geriatric Programs	--	20,000	20,000		28,383
HETC	280	280	275		264
Public Health Trng Cnter	8,000	---	---		----
Total - Short-Term	**40,280**	**54,387**	**52,429**		**56,701**
TOTAL	**46,637**	**68,232**	**68,350**		**69,786**

On average, long- and short-term primary care training targets were met in FY98. In total, the FY98 actual exceeded the targets for FY99 through FY01. The performance of the Geriatric program is especially noteworthy. The Geriatric program is the major source of training for health professionals

to care for the elderly. The Geriatric program FY99 training target of 20,000 health professionals was exceeded in FY98 by 42%.

Actual FY98 performance were significantly higher (25 percent or more) than performance targets for Family Medicine Faculty Development and General Internal Medicine/General Pediatric Faculty Development.

Scholarships for Disadvantaged Students: This program now includes funding that was previously made available as Exceptional Financial Need Scholarships and Financial Assistance for Disadvantaged Health Professions Students. As a result of consolidating these programs into the SDS program, the targets for FY99 through FY01 were increased from 2,400 to 3,100.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated Appropriations Act of 2000*, performance targets were revised to reflect the differences. These performance targets also reflect the phasing out of several Health Professions grants (i.e., Primary Care Medicine and Dentistry), because Federal efforts have demonstrated their effectiveness and are now shifted to other activities, such as improving access to care in rural and underserved communities and increasing opportunities for individuals from minority/disadvantaged backgrounds.

Goal II B. 1: Increase the Number of Minority/disadvantaged Graduates and Program Completers

Context:

Studies have shown that members of minorities and disadvantaged groups are more likely to set up practices which address the needs of the underserved. The number of minority/disadvantaged graduates and program completers provides an important indicator of the success of Title VII and VIII programs in assuring progress toward a diverse health-care workforce to meet the needs of a diverse population.

Performance:

	Targets			Actuals	
	FY01	FY00	FY99	FY99 (11/00)	FY98
Scholarships for Disadvantaged Students	3,473	3,473	3,473		2,357
GIM/GP Residency	--	123	126		167
GIM/GP Fac Dev Trainees	--	22	23		69
General Dentistry/Ped Dent	--	70	66		105
HCOP					
Post-Secondary	5,077	4,680	4,365		3,270
K - 12	2,516	2,075	900		1,098
Fam Med - Graduate Trng	--	136	138		297
Fam Med - Fac Dev Trainee	--	208	213		135
Podiatry	--	6	6		9
Physician Assistant	--	562	580		451
Allied Health	248	363	369		N.A. 1/
Public Health Traineeships	--	236	236		N.A. 1/
Preventive Medicine	--	11	11		N.A. 1/
Dental Public Health	--	6	6		8
Public Health training Center	1,500	---	---	---	N.A. 2/
Health Admin Traineeships	---	70	70		126
TOTAL	**12,814**	**12,035**	**10,652**		**8,092**

1/ N.A.: Not Available

2/ New Program–First Performance Data Available in FY01

FY98 performance of over 16,000 minority/disadvantaged enrollees exceeded the original FY99 target of 9,000 by 78%. As a result, several programs increased their FY99 through FY01 targets: SDS (tripled target), Nurse Practitioner/ Midwife (doubled target), Professional Nurse Traineeships (quintupled target), Nursing Education Opportunity (quintupled target), and Advanced Nurse education (doubled target). FY98 actuals were significantly higher (25 percent or more) than FY99 targets for: General Internal Medicine and Pediatric Residencies, General Internal Medicine and Pediatric Faculty Development, General Dentistry and Pediatric Dentistry, and Family Medicine Graduate Training.

Goal II.B. 2: Increase the Number of Minority/disadvantaged Enrollees

Context:

The goal of a diverse healthcare workforce is dependent, in part, on the number of young people minority/disadvantaged students who are motivated in elementary school and high school to succeed in the academically challenging work required for admission to health-care education. BHPr has initiated several outreach initiatives to encourage such students in elementary and high school and help them to see health professions as a realistic career choice. The number of minority/disadvantaged enrollees is an indication of success in assuring a prerequisite to a diverse workforce - minority/disadvantaged students choosing it as a career.

Performance:

	Targets			Actuals	
	FY01	FY00	FY99	FY99 Available 11/00	FY98
Scholarships for Disadvantaged Students	13,892	13,892	13,892		9,430
Nurse Practitioner/Midwife	500	500	500		567
Professional Nurse Traineeships	1675	1,675	1,675		1,686
Nursing Education Opportunity	1,500	1,500	1,500		1,597
Podiatry	0	6	6		5
Family Medicine - Grad Trng	--	416	416		449
Family Medicine - Fac Dev	--	208	213		48
GIM/Ped	--	381	381		248
GIM/GP Faculty Dvlpment	--	22	23		40
Physician Assistant Trng	--	1170	1,170		841
HCOP (Matriculants)	1015	936	880		800
HETC	280	280	275		264
Advanced Nurse Education	300	300	300		416
TOTAL	**19,162**	**21,286**	**21,231**		**16,391**

FY98 performance of over 16,000 minority/disadvantaged enrollees exceeded the original FY99 target of 9,000 by 78%. As a result, several programs increased their FY99 through FY01 targets: SDS (tripled target), Nurse Practitioner/ Midwife (doubled target), Professional Nurse Traineeships (quintupled target), Nursing Education Opportunity (quintupled target), and Advanced Nurse education (doubled target).

Data on minority/disadvantaged enrollees, like graduates, was not readily available for some grantees.

Grantees are now required to collect data on minority/disadvantaged graduates and students and it is anticipated that data collection will be improved this year. Performance targets were also changed to reflect changes in funding for specific program lines.

Goal II.B.3: Increase the Number of Underrepresented Minorities Serving as Faculty

Context:

There is mounting awareness that the effectiveness of the healthcare workforce is dependent on its sensitivity to the cultural differences which affect healthcare. The composition of the healthcare workforce should reflect, in general, the characteristics of the general population. Faculty members who are from underrepresented minorities have unique insights into the cultural component of healthcare and provide role models for future healthcare workers from underrepresented minority groups. The number of underrepresented minorities serving as faculty provides an indicator that is useful in monitoring several issues.

Performance:

	Targets			Actuals	
	FY 01	FY00	FY99	FY 99 Available 11/00	FY 98 Available 11/99
Loan Repayments and Fellowships regarding Faculty Positions	34	34	44		18
Family Medicine FacultyDevelopment Trainees	--	208	213		107
General Internal Med/Pediatrics - Faculty Devel. Trainees	--	22	23		71
Centers of Excellence - URM faculty	85	70	46		44
TOTAL	**119**	**334**	**326**		**240**

Several programs contribute to diversifying the faculty at health professions schools. Data is not yet available for two of the programs and not all grantees reporting had data on the number of

underrepresented faculty supported with health professions training grants. Grantees are now required to collect and report data on underrepresented faculty and it is anticipated that data collection will be improved this year.

Because of funding differences between the FY 2000 *President's Budget* and the *Consolidated Appropriations Act of 2000*, performance targets were revised to reflect the differences.

2.18 Program Title: Health Professions Workforce Information and Analysis

Performance Goals	Targets	Actual Performance	Reference
IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **A. Improve Information Development and Dissemination** 1. Increase the number of states that are being provided technical assistance in the use of workforce requirements, supply models and other workforce tools and analyses. (Revised)	FY 01: 5 FY 00: 5 FY 99: 5	FY 01: FY 00: FY 99: 5 FY 98: 4	B166
2. Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.	FY 01: 10 reports FY 00: 7 FY 99: 5	FY 01: FY 00: FY 99: 5 FY 98: 2 reports	B166
Total Funding: Workforce Information and Analysis ($ in 000's)	FY 2001: $714 FY 2000: $714 FY 1999: $714 FY 1998: $686	B x: page # budget HP: Healthy People goal	

2.18.1 Program Description, Context and Summary of Performance

Context:

About 15 cents of every dollar spent in the U.S. is on health care and one out of every 12 jobs (and growing) is in the health care industry. In spite of the magnitude of expenditures and employment in the health care industry, excepting physicians, relatively little is known of the health care workforce. For example, while public health is one of the most fundamental Federal, state and local government functions–responsible for addressing health care issues that account for 50 percent of all preventable deaths--there is no data available on the public health workforce. In the absence of data on the public health workforce, it is impossible to assess public health workforce needs versus supply, distribution, and training needs.

The investment in workforce information and analysis will result in more efficient allocation of resources and greatly reduce the Federal, State, and private expenditures in health care. For example, better information on the impact of health professional training on practice in underserved areas will result in better distribution of health care providers and lower Federal subsidies in health professionals education.

In recent years, health policymakers and groups of experts have advocated for a strong Federal government role in developing information and conducting analyses on health workforce supply, requirements, and distribution. Two such reports include findings from the Institute of Medicine (IOM): Primary Care: America's Health in a New Era, March 1996 and The Nation's Physician Workforce: Options for Balancing Supply and Requirements, February 1996. Many state and local governments have also voiced this need through numerous requests for assistance in analyzing their health workforce supply and requirements.

The Health Professions Workforce Information and Analysis program plays a critical role in ensuring health care access for the Nation. The goals of the program are to: (1) provide health workforce information and analyses to national, State, and local policy makers and researchers on a broad range of issues such as graduate medical education, Medicaid/CHIP, and health care workforce planning and (2) conduct Federal-State collaborative efforts directed at assessing the adequacy of the current and future local health care workforce and develop strategies for improving the diversity and distribution of their respective workforces.

A network of Federal/State Centers for health workforce research is being developed to forecast local health workforce supply and requirements. The following high-priority activities will be conducted with the proposed funding:

C Continued support of one Regional Center (or Center of Excellence). Working with the appropriate State officials, the Regional Center develops methodologies to: study local trends

in the supply and distribution of physicians, dentists, nurses, allied health and public health professionals; identify areas having localized shortages of these professionals; identify the causes of these shortages; and develop strategies for addressing the problem.

C Update health workforce data for those health professions that are currently on the Area Resource File (ARF) (the single most comprehensive health professions workforce database).

- Expand and adapt workforce requirement models for use at the state and local level to assess health care workforce issues and provide associated technical assistance.

The primary partners and customers are: 1) HRSA and the Bureau of Health Professions; 2) National policy makers and advisory councils such as the Congress, Council on Graduate Medical Education, National Advisory Council on Nurse Education and Practice, National Governors Association, National Conference of State Legislatures; 3) State policy makers and advisors such as State Health Departments and Primary Care Offices and Associations; and 4) the health policy research community such as PEW Health Professions Commission, Robert Wood Johnson Foundation, and academic research centers.

Program-wide performance:

The Area Resource File, the ARF, is the only comprehensive health workforce data base in existence. It is widely used by other Federal agencies (including: HCFA, AHRQ, NCHS, NIH, and SAMSHA), state and local agencies and the private sector. The regional Center of Excellence for Health Workforce Information and Analysis is very productive and conducts very topical studies that have wide ranging implications. For example, one such study examined the impact of anti-affirmative action legislation on minority enrollment in medical schools in the State of California. The study has implications for other States where anti-affirmative action legislation has been passed or considered and, more broadly, implications for the diversity of the health workforce in the country. The number of these policy-relevant studies is anticipated to increase 5-fold from 1998 to 2001. To aid national and state policymakers, models were also developed and refined to estimate requirements for physicians, nurse practitioners, and physician assistants. Extensive technical assistance in using these models was provided to 4 states.

2.18.2 Goal-by-Goal Presentation of Performance

Goal IV.A.1: Increase the number of states that are being provided technical assistance in the use of workforce requirements, supply models and other workforce tools and analyses. The goal targets and actual performance were revised to reflect the level of appropriated funding.

Context:

Health workforce requirement models, tools, and analysis are needed by States for planning health professionals education, to assess access issues, and in planning to meet future health care needs.

Performance:

The baseline reflects current performance and the targets are based on program planning estimates. The number of states that provided technical assistance indicates the breadth of use of the workforce tools developed under this program.

Goal IV.A.2: Annually produce results of data collection and analysis activities conducted to inform the market regarding issues relevant to health professions and nursing workforce.

Context: Workforce analysis is needed to plan and implement the Bureau's health professions training programs. It is also needed by other HRSA programs, the Health Care Finance Administration, the Council on Graduate Medical Education, Federal and State and local policymakers, health policy research organizations, and professional associations.

Performance The number of health workforce analyses conducted is an indicator of the number of workforce issues analyzed and a measurement of the applied, relevant nature of the program. In addition to developing tools, the National Center for Health Workforce Information and Analysis also conducts research on topical or current workforce issues and compiles data and descriptive reports on the health professions. These important products are used by a wide range of healthcare planners, policy analysts, students, and researchers. The goal targets and actual performance were revised to reflect the level of appropriated funding.

2.19 Program Title: Children's Hospital Graduate Medical Education Program

Performance Goals	Targets	Actual Performance	Refe r- ence*
I. Eliminate Barriers to Care **A. Increase Utilization for Underserved Populations** 1. Maintain the number of FTE residents whose training is supported by the grantee children's hospital. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
2. Maintain the percentage of residents' training that is supported in rural and medically underserved areas. (Developmental)	FY 01: Not established FY 00: Not established FY 99: Not applicable	FY 01: FY 00: FY 99: NA	B175
II ELIMINATE HEALTH DISPARITIES **B. Increase Utilization of for Underserved Populations** 1. Improve Percentage of minority residents. (Developmental)	FY 01: Not established FY 00: Not established FY 99: Not applicable	FY 01: FY 00: FY 99: NA	B175

Performance Goals	Targets	Actual Performance	Refe r- ence*
IV IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **A. Improve Information Development and Dissemination** 1. Monitor financial status of hospitals (total and operating margins). (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
2. Monitor the proportion of uncompensated care patients. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
3. Monitor the proportion of Medicaid patients. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
B. Promote Education and Training of the Public Health and Health Care Workforce 1. Improve the percentage of graduated residents passing their board exams on the first attempt. (Developmental)	FY 01: Not established FY 00: Not established FY 99: NA	FY 01: FY 00: FY 99: NA	B175
Total Funding: Children's Hospital Graduate Medical Education ($ in 000's)	FY 2001: $80,000 FY 2000: $40,000 FY 1999: 0	B x: page # budget HP: Healthy People goal	

2.19.1: Program Description, Context and Summary of Performance

Context:

Under the formulas to fund children's teaching hospitals, approximately 59 hospitals that have their own provider number, receive little compensation from Medicare for graduate medical education (GME) and other health professions training. As managed care organizations become increasingly unwilling to pay for GME, the lower level of Medicare support puts an undue burden on these hospitals in competing for private and Medicaid managed care contracts. In the absence of commensurate support for direct medical education, freestanding children's hospitals will have an increasing incentive to reduce the number of pediatric residents and services provided to their communities. The Children's Hospital Graduate Medical Education Program makes the level of support more consistent with other teaching hospitals so that the level of training in children's hospitals keeps pace with the need.

Payments for direct graduate medical education activities are determined by a formula based on a standardized per resident amount that takes into account wage and non-wage related portions. Payments will also be provided for indirect graduate medical education purposes and will take into account the case-mix index for a children's hospital. Payments will support the training of resident physicians as defined by Medicare in both ambulatory and inpatient settings.

This program is designed to augment the minimal funding provided by Medicare for graduate medical education in freestanding children's hospitals. Coordination with HCFA will continue throughout the development and administration of the program. We continue to work closely with potential grantees to plan the program and identify information needs.

Program-wide performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002.

Program-level data issues:

FY 2000 is the first year of the program's operation. The program is expected to collect data from participating hospitals which address the financial status of the hospital and various training program measures. During Fiscal Year 1999, the Bureau began working with potential grantees and professional associations to develop performance measures.

2.19.2 Goal-by-Goal Presentation of Performance

These goals are considered developmental. During the first year, an assessment will be made of the feasibility of collecting appropriate data.

Goal I.A.1. Maintain the Number of Pediatric Trainees

Context:

The health care workforce environment requires that sufficient numbers of physicians be appropriately and adequately trained to care for pediatric populations. As freestanding children's hospitals experience financial pressures common to the academic health center community, there may be increased interest in reducing or eliminating training programs. These hospitals and their training programs provide a significant service to the local, regional and sometimes national community. A reduction in training programs would impact the provision of those services as well as the production of one quarter of the Nation's pediatricians and the majority of pediatric specialists.

These data elements provide an accurate accounting of the number of resident FTEs training in children's hospitals. In addition to performance and trend analysis considerations, these numbers are fundamental to determining the FTE number upon which payments will be made.

Performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the aggregate number of FTE residents who are:

- In the grantee children's hospital and sponsored by the hospital
- rotating into the grantee hospital from residency programs sponsored by other institutions
- sponsored by the grantee hospital and rotating to other hospitals

Goal-level data issues:

The numbers of trainees in a given hospital's training program is currently collected by the Health Care Financing Administration (HCFA) for those freestanding children's hospitals that opt to request reimbursement from Medicare. Not all freestanding children's hospitals that are eligible for participation in the CHGME Program have submitted such information to HCFA. Generally, each hospital has a fairly good accounting of the number of trainees in its programs. Accounting for the number of trainees rotating to a freestanding children's hospital for a portion of their training is more complicated. A few children's hospitals have begun to quantify the number of trainees rotating to their hospital from other training programs. Hospitals will have to establish the infrastructure to accurately account for trainees eligible to be counted for the purposes of the CHGME Program.

Goal IA 2. Increase in the Proportion of Residents Serving Underserved Populations

Context: Access research has focused on the contribution of physicians serving the underserved. Access to care is significantly improved when physicians are serving the underserved. Residency training programs located in rural and MUCs provide much needed care in their communities while residents are learning the knowledge, skills and attitudes necessary to adequately and appropriately care for rural and underserved populations.

Performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the proportion of residents training in medically underserved communities (MUCs) and rural areas. The definition for the designation of rural areas shall be adopted from the United States Department of Agriculture's Urban-Rural County Continuum Code classification system. The definition of a MUC shall be consistent with the definitions currently utilized by HRSA.

Goal-level data issues:

Hospitals and their training programs do not routinely report nor calculate information regarding training locations and populations served in residency training programs.

Goal II.B.1. Improve Percentage of Minority Residents

Context:

Numerous studies have demonstrated that increasing the diversity of the physician workforce will improve access to care as underrepresented minorities are more likely to practice in "socioeconomically deprived" areas and to enter generalist specialties.

Communities with high proportions of black and Hispanic residents are four times as likely as others to have a shortage of physicians, regardless of community income. In a recent California study, black physicians cared for significantly more black patients and Hispanic physicians cared for significantly more Hispanic patients than did other physicians. (Komaromy, M, et al: The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations. New England Journal of Medicine 1996; 334(20):1305-10.)

According to a survey of graduating medical students performed by the Association of American

Medical Colleges, underrepresented minorities were four times more likely to indicate that they plan to practice in areas characterized as "socioeconomically deprived" than other graduates. Additionally, the respondents indicated that underrepresented minorities were more likely to enter generalist specialties. (AAMC: Specialty Choice, Intended Practice Location, and Ethnic Identity: Career Plans of the 1996 Graduating Medical School Class. AAMC Fact Sheets 1997; 1(11):1.)

Performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the percentage of and race/ethnicity of residents in each program.

Goal-level data issues:

Data on the race and ethnicity of trainees is not routinely collected by training programs or hospitals. The information will be requested on an annual application submitted by each participating hospital.

Goals IV.A.1 Monitor Trends in the Financial Status of Participating Hospitals

IV.A.2 Monitor the Proportion of Uncompensated Care Patients

IV.A.3 Monitor the proportion of Medicaid Patients

Context:

Children's hospitals by several measures have poorer financial status than most other teaching hospitals. In 1995, 58% if these hospitals had negative operating margins. Compounding this have been the major changes in the health care system. Factors such as increased pressure at all levels of health care, the expansion of managed care, and the increased effort to constrain health care costs may put health facilities that train physicians at a competitive disadvantage in the new marketplace. In the competitive marketplace, payers of health care services have few, if any, incentives to pay higher costs to sites that train health professionals.

Performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the: 1) Total and operating margins, 2) Percentage of patients served enrolled in Medicaid and 3) Percentage of uninsured patients and uncompensated care.

Goal-level data issues:

Most children's hospitals collect such information for their own purposes. Some may be reluctant to

share detailed financial information for various reasons including privacy.

Goal IV.B.1. Improve or Maintain the Percentage of Residents Passing their Board Exams

Context:

Numerous studies have utilized measures of board pass rate as an indicator of quality of training, knowledge and skills.

Performance:

This program was not implemented until Fiscal Year 2000 and no performance data will be available until FY 2002. Each hospital will be asked to submit on an annual application the percentage of graduated residents passing their board exams on the first attempt.

Goal-level data issues:

The timing of the exams will impact when the information can be made available for the purposes of the CHGME Program. The children's hospitals will not be able to readily collect board scores and pass rates for resident trainees rotating in from programs sponsored by other hospitals.

2.20 Program Title: Health Education Assistance Loans (HEAL)

Performance Goals	Targets	Actual Performance	Reference
IV. IMPROVE PUBLIC HEALTH AND HEALTH CARE SYSTEMS **B. Promote Education and Training of the Public Health and Health Care Workforce** 1. Conduct an orderly phase-out of the outstanding loan portfolio.	FY 01: $3,500,000,000 FY 00: $3,600,000,000 FY 99: $3,700,000,000 FY 98: $3,800,000,000	FY 01: FY 00: FY 99: $3,700,000,000 FY 98: $3,800,000,000	B277
2. Reduce the amount of HEAL claims to be paid from the liquidating account. (Amount paid)	FY 01: $10,000,000 FY 00: $35,000,000 FY 99: $38,000,000 FY 98: $50,000,000	FY 01: FY 00: FY 99: $27,087,241 FY 98: $38,295,256	B277
Total Funding: HEAL ($ in 000's)	FY 01: $13,679 FY 00: 18,687 FY 99: 40,679 FY 98: 34,261		

2.20.1 Program Description, Context and Summary of Performance

Context:

The HEAL program's authority to make new loans expired in FY 1999. The program was created to provide last dollar financial support to students of diverse socio-economic backgrounds attending schools of allopathic medicine, osteopathic medicine, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, health administration, clinical psychology, and chiropractic. Since the program's inception, $4,000,000,000 has helped 156,000 students pay for their health professions education. The program continues to have an outstanding portfolio of more than $3,700,000,000 which will not be fully repaid until the year 2031.

Although authority to make new HEAL loans expired in FY 1999, the outstanding loan portfolio of more than $3.7 billion will require management and oversight until 2031, when the last loan is fully repaid. HEAL program activities include developing default reduction and prevention efforts designed to help borrowers manage their indebtedness and remain in practice, and partnering with lenders and holders to assure that HEAL claims payments continue to decline. HEAL Refinancing is an ongoing initiative that provides borrowers with significant savings in loan payments and reduces both the total Federal liability and the actual default payments made by the Federal Government. As part of its efforts to induce repayment from defaulters and deter other borrowers from defaulting, the HEAL program maintains an Internet listing of HEAL defaulters who are excluded from the Medicare program. The HEAL portfolio is also being analyzed to determine the feasibility of developing other innovative approaches for preventing defaults and rehabilitating defaulted borrowers, especially among underrepresented minority (URM) borrowers, in order to keep URM health professionals in practice and improve access to care.

The HEAL program works closely with lenders and holders to analyze loan activity and assure that loan collection procedures are structured in a manner that minimizes defaults. In addition, as part of its default prevention and reduction efforts, the HEAL program provides technical assistance to States that are interested in suspending professional licenses of HEAL defaulters. The HEAL program also coordinates with the Office of Inspector General regarding the publication of HEAL defaulters who are excluded from the Medicare program.

Program-wide performance:

The HEAL program remains committed to proper management and oversight of the $3,700,000,000 outstanding loan portfolio. This includes providing the 101,063 HEAL borrowers who have not yet fully repaid their loans with appropriate assistance to facilitate the repayment of their loans, working with borrowers, lenders, and loan holders to minimize defaults, and aggressively pursuing HEAL defaulters.

2.20.2 Goal-by-Goal Presentation of Performance

Goal IV.B.1: Conduct an orderly phase-out of the loan insurance authority.

Context:

Although the authority to make new HEAL loans expired in FY 1999, the outstanding loan portfolio of more than $3,700,000,000 will require management and oversight until 2031, when the last loan is fully repaid.

Performance:

Because the authority to make HEAL loans expired in FY99, the performance goals have been changed from a measure of awards made to repayment of loans and phase-out of the outstanding loan portfolio. The baseline level represents original loan amounts and accrued interest for the HEAL outst**a**nding loan portfolio. Target estimates reflect the results of HEAL default reduction and prevention efforts and the repayment of HEAL loans.

Goal IV.B.2 Reduce the amount of HEAL claims to be paid from the liquidating account.

Context for the goal:

HEAL program initiatives include a strong emphasis on innovative activities including loan refinancing designed to reduce the amount of HEAL claims to be paid from the liquidating account. This will minimize the Federal liability associated with the HEAL program.

Performance:

The baseline and targets were established using the HEAL claims projection model that has been developed by HEAL program officials in conjunction with the Office of Management and Budget. This model considers numerous variables that affect HEAL claims payment amounts. These levels have been established using the HEAL claims projection model, which is based on historical HEAL trends. The FY 99 Actual Performance for HEAL claim payed was significantly lower than the FY 99 Target due to tight management control.

2.21 Program Title: National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB)

Performance Goals	Targets	Actual Performance	Ref.
III. ASSURE QUALITY OF CARE **B. Assure Effectiveness of Care** 1. Increase the use of the NPDB and HIPDB for decision-making by queriers.	NPDB FY 01: 4,300,000 q* 14,350 d* FY 00: 4,000,000 q* 13,350 d* FY 99: 3,200,000 q* 10,400 d* HIPDB FY 01: 1,800,000 q* 1,800 d* FY 00: 700,000 q* 700 d* * q = Queries. *FY 00 and FY 01 NPDB estimates include increased querying resulting from projected adoption of "Section 5"* * d = Decisions affected by responses	NPDB FY 01: FY 00: FY 99: 3,235,621 q* 10,800 d* FY 98: 3,164,119 q* 10,000 d* HIPDB FY 01: FY 00: * q = Queries. * d = Decisions affected by responses	B187

Performance Goals	Targets	Actual Performance	Ref.
2. Increase the number of databases the NPDB and HIPDB use as information sources to improve the quality of information in the NPDB and HIPDB.	FY 01: 4 data bases FY 00: 3 data bases FY 99: 2 data bases	FY 01: FY 00: FY 99: 2 FY 98: 1	B187
Total Funding: National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank	FY 01: $17,200,000 NPDB uf* $ 4,317,000 HIPDB uf* $ 2,443,000 HIPDB app* $23,960,000 FY 00: $16,000,000 NPDB $ 3,238,000 HIPDB uf* $ 916,000 HIPDB appr* $20,154,000 FY 99: $15,636,000 NPDB uf* $ 4,433,000 HIPDB appr* $20,069,000 FY 98: $12,051,527 NPDB uf* $ 1,000,000 HIPDB appr* $13,051,527 *appr = HCFAC Account appropriated funds; FY 00 is President's budget, FY 01 is an estimate; actual funding to be based on allocation by the Secretary of HHS and the Attorney General based on FY 01 appropriation. *uf = user fees		B187

2.21.1 Program Description, Context and Summary of Performance

Context:

Prior to establishment of the National Practitioner Data Bank (NPDB) a healthcare practitioner could easily escape the scrutiny of medical oversight organizations simply by moving to another state. The NPDB provides a national data repository which can be accessed by licensing, privileging, and credentialing authorities prior to granting licensure or extending clinical privileges. The NPDB tracks all significant adverse professional actions against physicians and dentists as well as malpractice settlements and judgments against all licensed health care professionals.

HRSA is developing and operating the Healthcare Integrity and Protection Data Bank (HIPDB) for the OIG and the Department of Justice to implement a requirement of the Healthcare Insurance Portability and Accountability Act of 1996. The HIPDB is operated in conjunction with the NPDB. It augments information available in the NPDB and will assist the NPDB in implementing reporting of licensure and clinical privileging information for practitioners other than physicians and dentists when "Section 5" regulations are adopted. The HIPDB opened for reporting in November 1999 and will open for queries in early 2000.

Medical malpractice insurance companies, State licensing boards, health care entities such as hospitals, HMOs, group practices and professional societies are required to report information to the NPDB on paid medical malpractice judgments and settlements, sanctions, certain professional review actions, and adverse membership actions involving licensed practitioners. The NPDB also receives reports of practitioner exclusions from the Medicare and Medicaid program. Hospitals are required to query the NPDB and currently are responsible for about 1/3 of all queries to the NPDB. State licensure agencies, and health care entities and professional societies which meet certain requirements are permitted to query the NPDB. These voluntary queriers submit about 2/3 of all queries to the NPDB. The NPDB is funded through user fees (currently a base fee of $4.00 per query) rather than appropriated funds.

Health plans and federal and state programs and officials (including licensing agencies, certification agencies, criminal prosecutors, government attorneys participating in civil cases, and agencies taking program exclusion actions) are required to report to the HIPDB all final adverse actions (such as revocations, suspensions, exclusions, criminal convictions and civil judgments) against health care providers, suppliers, and practitioners. Federal and State agencies and health plans are permitted to query the HIPDB. Although appropriated funds were used to develop the HIPDB, once it is fully operational, it will be funded through user fees (expected to be a base fee of $4.00 per query) rather than appropriated funds.

The services provided by the NPDB operation will be augmented by the opening of the HIPDB during

FY 00. The NPDB and HIPDB programs will be operated so that entities required to report to both data banks need only file one report and queriers eligible to obtain information from both data banks need only query once. In addition to information required to be reported by law to the NPDB, the Department has agreements for voluntary reporting and querying by the Department of Defense, the Department of Veterans Affairs, and the Department of Justice, Drug Enforcement Administration. Medicare and Medicaid exclusions also are reported by HCFA and the OIG.

Program-wide performance:

As of September 30, 1999, the NPDB contained 221,635 reports on 142,432 practitioners. Approximately 76% of these reports concerned malpractice payments; approximately 15 percent concerned licensure actions. Slightly more than 5 percent were Medicare/Medicaid exclusions. Most of the remainder were clinical privileges actions. Almost 72% of the practitioners with reports were physicians. About 15% were dentists. Although 71% of practitioners with reports in the NPDB have only one report, the NPDB has an average of 1.56 reports for each practitioner with reports. During FY 99, the NPDB processed 3,235,621 queries from more than 9,600 registered entities. Querying entities received 399,943 responses from the NPDB which contained reports on the queried practitioners. They also received 2,835,318 responses which confirmed that the named practitioner had no malpractice payments, adverse actions, or exclusions since September 1, 1990. During FY 99 the NPDB also provided responses to 41,925 self-queries from practitioners. Of these responses, 3,753 contained reports; the remainder confirmed that the practitioner had no reports on file in the NPDB. The HIPDB had not yet begun receiving queries during FY 99.

Program-level data issues:

The NPDB has conducted user surveys to obtain data concerning user satisfaction and the usefulness of the program. A series of such surveys have been conducted by a contractor and the OIG in previous years. The University of Illinois at Chicago is currently under contract to conduct a new survey on program usefulness and user satisfaction. Survey respondents will rate the NPDB on how easy it is to report to and obtain information from the NPDB, the completeness and accuracy of the information provided, how significant NPDB information is for their decision making process, and other factors. Results of this study are expected during FY 2000.

The usefulness of the NPDB program can also be inferred from the fact that entities which are not legally required to query pay more than $8,000,000 each year to submit over 2,000,000 queries to the NPDB. These entities would not query if they did not believe the NPDB provides them with important information.

2.21.2 Goal-by-Goal Presentation of Performance

Goal III.B.1. Increase the use of the NPDB and HIPDB for decision-making by queriers.

Context:

NPDB query response information is used by licensing boards, hospitals and other health care entities, and professional societies for licensing, privileges, and membership decisions. NPDB responses which include matched malpractice payment, adverse action, or exclusion report information have been demonstrated to affect entity decisions from 2 to 3% of the time depending on the type of entity making the query. According to OIG and consultant studies, matched responses containing NPDB reports also are valuable to querying entities when they confirm information the entities have received from other sources. NPDB "no-match" responses are likewise valuable according to survey results because these responses confirm that a practitioner has had a "clean" record since September 1, 1990. These "no-match" responses will become even more valuable as the number of years of reporting to the NPDB increases.

The NPDB serves as a central reliable source of (mostly) adverse information concerning practitioners. Practitioners may fail to include this adverse information in their licensure, privileges, or membership applications if they think that their omissions will not be discovered. Indeed, the proclivity of practitioners with less than perfect records to omit damaging information on applications was a major reason for adoption of the Health Care Quality Improvement Act of 1986, which led to the establishment of the NPDB. The existence of the NPDB makes it difficult, if not impossible, for practitioners to successfully hide damaging information from NPDB queriers. Because of the existence of the NPDB, practitioners now are more likely to disclose damaging information in their applications, presumably because they believe it would be seen as even more damaging if it appears that they were attempting to hide the information.

Eligible entities will begin querying the HIPDB during FY 00. We expect substantial numbers of queries to the HIPDB because it will contain several types of data not found in the NPDB (such as licensure actions on practitioners other than physicians and dentists and criminal convictions and civil judgments) and because it will contain information on providers and suppliers as well as practitioners. The accuracy of this expectation has been confirmed by the fact that during the HIPDB registration/NPDB re-registration process (as of the end of December 1999), almost three-quarters of all entities eligible to query both the NPDB and the HIPDB chose to query both data banks once the HIPDB opens for querying.

Performance:

Data from our entity user file supplied by the NPDB contractor indicate that the NPDB provided responses for 3,235,631 queries from entities during FY 99, this is an increase over the FY 99 Target. Queriers received 399,943 matched responses containing report information. Based on previous user surveys conducted by the OIG, an estimated 10,800 licensure, credentialing, or membership decisions

were affected by these match responses during FY 99. Using the survey information combined with current querying and response data is the most reliable available method to estimate the impact of the NPDB on decision making.

The NPDB also provided confirming information, which survey responses indicate are also generally viewed as useful by queriers an estimated 389,100 times during 1998. In addition, the NPDB confirmed that practitioner had a clean record 2,835,318 times during 1998. User surveys also indicate that this information is generally considered important by users. We expect that as the number of NPDB queries continues to slowly increase and the match rate also continues to increase, the number of decisions directly affected by NPDB information will also continue to increase as shown in the table above. It should be noted that the numbers shown above do not include any increase in querying which may result from the opening of the HIPDB or possible adoption of Section 5 regulations which would increase the number and types of reports to the NPDB.

It also should be noted that, paradoxically, the extent to which decisions are changed because of new information received from the NPDB may decrease as a greater proportion of practitioners submit complete and fully accurate applications which do not omit any negative information. This would not indicate that the NPDB is becoming less effective, but rather that its importance as a deterrent is increasing.

The OIG found that in 1992 (two years after the NPDB opened) 40% of practitioner's applications to hospitals omitted some information contained in NPDB reports. A later OIG study found that by 1994 (four years after the NPDB opened) only 28% of applications were incomplete. We anticipate that practitioners will continue to become more conscientious in completing applications as it become even more apparent that omissions will be discovered because of information from the NPDB. The current survey and future surveys will measure this impact.

No data are available to determine how many patients were saved from substandard care or improper practitioner behavior as a result of these decisions and it is unlikely that reliable data of this type could be developed.

The performance targets were increased by 21% in FY00 and 26% in FY01 to reflect the trend in actual performance. New performance targets are presented for the Health Integrity and Protection Data Bank, a program that began operation in FY00.

Goal-level data issues:

Increased querying implies increased use of NPDB and HIPDB information for decision making. We

currently measure our success in reaching the goal in terms of the number of queries submitted, which is easily measurable, and in terms of decisions affected, which is not easily measurable. Data on decisions affected, i.e., how NPDB and HIPDB data is actually used, can be obtained only from surveys of NPDB and HIPDB users. We based our counts of decisions affected on previous survey results and current information from the NPDB contractor on the number of queries and matched responses. Surveys to obtain information on user satisfaction and how NPDB query responses are used are expensive and are not conducted every year. Survey data are subject to sampling and data collection errors. We have no reason to believe, however, that there are any significant errors in the currently available survey data. As noted above, a new survey is currently being conducted. This survey will allow us to refine the decisions affected counts in the future.

NPDB query data for future years is estimated taking into account possible changes resulting from implementation of the HIPDB and "Section 5." If "Section 5" is not implemented, these estimates will be excessive. The number of queries shown for FY 99 is the actual number of queries processed by the NPDB. "Decisions affected by responses" is an estimate based on survey data and the actual number of queries which resulted in match responses during the year.

HIPDB query and decisions affected data are based on our HIPDB business plan and budget estimates and registrations for querying the HIPDB. FY 00 estimates assume a February 1 opening date for querying. The estimated number of decisions affected by HIPDB reports is based on an assumed initial 2 percent match rate and an assumption that 5 percent of HIPDB matches will provide new information which affects decision making. These estimates will be revised as experience is gained with these programs after they become operational.

Data on the frequency with which practitioners withhold information on applications that is disclosed by the NPDB can be obtained only through surveys of NPDB users. Such surveys are expensive and are not conducted every year. Like all survey data, this type of information is subject to sampling and data collection errors. Nevertheless, the data collected on this issue by the OIG are the most reliable available. We are gathering updated information on this issue in the survey of NPDB users currently in progress.

Goal III.B.2: Increase the number of databases which are used by the NPDB as information sources to improve the quality of information in the NPDB.

Context:

The NPDB's information can be improved by obtaining information when needed (such as to confirm license numbers, addresses, etc.) from other sources. This information is used to help resolve "partial matches," those situations in which the NPDB cannot initially determine with reasonable certainty that the practitioner about whom information is being sought is a the same practitioner on whom

information has been reported to the NPDB. Such problems arise when queries do not have complete information. These problems also may arise when practitioners have the same or similar names.

Performance:

The NPDB currently confirms practitioner identification and characteristics information using the AMA data base when necessary. The NPDB also obtains information from State licensure boards as necessary to identify practitioners. As practitioner information becomes increasingly available on the Internet, the NPDB plans to increase use of these sources, not only for physicians but also for other types of practitioners. When the HIPDB opens, the NPDB will also coordinate with the HIPDB for needed practitioner identification information.

2.22 Program Title: National Vaccine Injury Compensation Program (VICP)

Performance Goals	Targets	Actual Performance	Reference
III. ASSURE QUALITY OF CARE **C. Improve Customer/Patient Satisfaction** 1. Process payment of 90 percent of annuities within 60 calendar days of receipt of a Department of Justice (DOJ) clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 96.0% FY 98: 92.6%	B293
2. Process payment of 90 percent of lump sum awards within 30 calendar days of receipt of a DOJ clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 90.9% FY 98: 93.8%	B293
3. Process payment of 90 percent of attorney fees within 30 calendar days of receipt of a DOJ clearance letter.	FY 01: 90% FY 00: 90% FY 99: 90%	FY 01: FY 00: FY 99: 96.9% FY 98: 96.6%	B293
Total Funding: National Vaccine Injury Compensation Program (VICP) ($ in 000's)	FY 2001: $ 117,347 FY 2000: $65,300 FY 1999: $ 155,889 ($100 million for pre- FY '89 claims) FY 1998: $55,500	Bx: page # budget HP: Healthy People goal	

2.22.1 Program Description, Context and Summary of Performance

Context:

The National Childhood Vaccine Injury Act of 1986 established the VICP to equitably and expeditiously compensate individuals, or families of individuals, who have been injured by childhood vaccines. The VICP serves to steady a previously perilous vaccine supply by substantially reducing the threat of liability for vaccine companies, physicians, and other health care professionals who administer vaccines.

An individual claiming injury from a covered vaccine files a petition for compensation with the United States Court of Federal Claims (the Court). A DHHS physician reviews the claim to determine that it meets the criteria for compensation and makes a recommendation to the Court. If the Special Master, appointed by the Chief Judge of the Court, is satisfied that an injury was caused by a covered vaccine, the VICP makes the appropriate payments based on the decision rendered by the Court. Awards are paid out of a trust fund financed through collection of an excise tax levied on each dose of covered vaccine administered.

The VICP is administered in close coordination with the U.S. Court of Federal Claims and the Department of Justice, whose attorneys represent the VICP during the proceedings before the Special Master. The nine member Advisory Commission on Childhood Vaccines meets quarterly to advise the Secretary on program structure and implementation.

Program-wide performance:

The VICP has been very effective. Since it was implemented in 1986 the number of lawsuits alleging DTP vaccine-caused injury dropped from 255 to just 4 in 1997 while filings for investigational new drug exemptions for non-AIDS vaccines rose from 17 in1987 to 49 in 1997.

Program-level data issues:

The VICP maintains a highly controlled internal data system, which contains detailed case-specific data values for the over 5,000 claims filed. This control data system includes legal, epidemiological, medical, diagnostic, and payment information, and is used for often highly complex cross-linking data analysis. Information contained in these tables have been reviewed and validated by the Office of Inspector General (OIG), the General Accounting Office (GAO), the Congressional Budget Office, and Agency and Departmental independent actuarial contractors.

Additionally, the OIG conducted a comprehensive Program study in 1992, and released a very favorable report on the management, operations, and success of the VICP. This study was eventually submitted to Congress to satisfy a statutory reporting requirement. Currently, the GAO is conducting a program review at the request of Senator Jeffords. The GAO has indicated that the results of the

report will be favorable. It is scheduled to be released on January 22, 2000. Further, the GAO has scheduled a follow-on review of specific financial components of the program pursuant to a request by the House Ways and Means Committee and the Senate Finance Committee.

2.22.2 Goal-by-Goal Presentation of Performance

Goal III.C.1: Process payment of 90 percent of annuities within 60 calendar days of receipt of a Department of Justice (DOJ) clearance letter.

Context:

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of annuities contributes materially to its success.

Performance:

Performance standards were conceptualized, developed, and implemented following careful consideration by program officials, and in partnership with the Department of Justice, Office of the General Counsel, VICP Petitioners' Attorneys, and the Advisory Commission on Childhood Vaccines. Standards were, in part, based on requirements of the Prompt Payment Act and customary business practices in the private sector, with emphasis made on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of the program. Additionally, the VICP negotiates and purchases annuity contracts, and requires the monitoring of market conditions, necessitating a payment system that mirrors (and exceeds) the private sector. Clairms are paid in a exceptionally timely, efficient manner. In FY 1999, 96.0 percent of annuities were processed within 60 calendar days. This exceeds the target by 6.0 percentage points.

Goal III.C.2: Process payment of 90 percent of lump sum awards within 30 calendar days of receipt of a DOJ clearance letter.

Context:

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of lump sums contributes materially to its success.

Performance:

See the performance statement for III.C.1.

Lump sum awards are paid in an exceptionally timely, efficient manner. In FY 1999, 90.9 percent (exceeding the target of 90 percent) of lump sum awards were processed within 30 days.

Goal III.C.3: Process payment of 90 percent of attorney fees within 30 calendar days of receipt of a DOJ clearance letter.

Context for the goal:

Timely, efficient resolution of claims is one of the primary objectives of the VICP and prompt payment of attorney fees contributes materially to program success.

Performance:

See the performance statement for III.C.1. Payments for attorney's fees were made in a very timely, efficient manner. In FY 1999, 96.9 percent of payments for attorney's fees were processed within 30 days, compared with a target of 90 percent.

2.23 Program Title: Ricky Ray Hemophilia Relief Fund Program (RRHRP)

Performance Goals	Targets	Actual Performance	Reference
III. ASSURE QUALITY OF CARE **C. Improve Customer/Patient Satisfaction** 1. Issue Notice of Intent Case Number letter to each individual that files a Notice of Intent to File a Petition with RRHRP.	FY 01: 100% FY 00: 100% FY 99: 65%	FY 01: (11/01) FY 00: (11/00) FY 99: 70%	B267
2. Complete the determination whether a petition meets the requirements of the Act no later than 120 days after the date a completed petition is filed with RRHRP. (Dependent upon completion of program regulations)	FY 01: 100% FY 00: 100% FY 99: NA	FY 01: (11/01) FY 00: (11/00) FY 99: NA	B267
3. Subject to availability of sufficient amounts in the Fund, process payment of 90 percent of petitioner payment awards within 30 calendar days of approval of a completed petition. (Dependent upon completion of program regulations)	FY 01: 90% FY 00: 90% FY 99: NA	FY 01: (11/01) FY 00: (11/00) FY 99: NA	B267
Total Funding: Ricky Ray Hemophilia Relief Fund Act of 1998 ($ in 000's)	FY 2001:$100,000 FY 2000: $ 75,000 FY 1999: $ 0	B x: page # budget HP: Healthy People goal	

2.23.1 Program Description, Context and Summary of Performance

Context:

The Ricky Ray Hemophilia Relief Fund Act of 1998 (the "Act") was signed on November 12, 1998 to provide for "compassionate payments" of $100,000 by the Secretary to certain individuals who acquired HIV infection from treatment with antihemophilic factor during the period July 1, 1982 through December 31, 1987. Section 101 of the Act establishes in the Treasury of the United Sates a trust fund known as the Ricky Ray Hemophilia Relief Fund. The Act authorizes appropriations to the Fund of $750,000,000. The FY 2000 Labor/HHS/Education appropriation provided funding to initiate this program.

On March 24, 1999, the Secretary established as a first procedure under the Act the opportunity for individuals to file Notices of Intent to File Petitions, which may lead to later filings of full petitions and determinations on those petitions when appropriate.

HRSA is currently developing regulations to implement the Act and to determine the policies and procedures for submitting a full petition and for prioritizing payments, as required. Subsequent to the issuance of these regulations, individuals may submit petitions for compassionate payments from the Fund. HRSA will review each petition and supporting medical and legal documentation and make recommendations regarding the petitions for compassionate payment. Subject to the availability of appropriated funds, HRSA will process award payments on approved petitions for compassionate payment.

The program is administered in close coordination with HRSA's Office of General Counsel and officials within HRSA's Bureau of Health Professionals. The program has also consulted with national hemophilia advocacy groups with regard to the programs policies and procedures. The Ricky Ray Program Office has already received more than 5,700 Notices of Intent to File a Petition. The Ricky Ray Program Office has responded to each Notice of Intent with an acknowledgment letter reflecting a case number assigned to the filing. The name, address and phone number of each petitioner, together with the name address and phone number of the petitioner's attorney of record, or other representative for the petition, if any, has been added to a database. The Ricky Ray Program Office will advise those who submitted Notices of Intent of the content, format, and deadlines for future submissions related to the petition.

On December 10, 1999, HRSA published a notice of a proposal to add a new system of records, in accordance with the Privacy Act of 1974. The new system is titled "Ricky Ray Hemophilia Relief Fund Act of 1998, HHS/HRSA/BHPr. HRSA has also established the Ricky Ray Hemophilia Relief Fund in the Department of the Treasury and organized accounting and auditing procedures for payments of awards.

The Ricky Ray Program Office , in conjunction with departmental contractors, will maintain a highly controlled data system, which will contain detailed case-specific data for the petitions filed under the Program. This control data system will include legal, medical, diagnostic, and payment information, to be used in the review process for determining whether a petition meets the requirements of the Act.

2.23.2 Goal-by-Goal Presentation of Performance

Goal III.C.1: Issue Notice of Intent Case Number letter to each individual that files a Notice of Intent to File a Petition with RRHRP.

Context:

The Notice of Intent to File a Petition system was established by the Secretary as the initial procedure for individuals who may wish to file a full petition. Subsequent to the issuance of Program regulations, the RRHRP will advise those who submit Notices of Intent of the content, format and deadlines for filing full petitions under the Act.

Performance:

Performance standards were conceptualized, developed, and implemented following careful consideration by Program officials, in concert with the Office of the General Counsel (OGC). Standards were, in part, based on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of this Program. As of January 14, 2000, the RRHRP has issued a Case Number letter to 100% of all individuals that have filed a Notice of Intent to File a Petition with the RRHRP.

Goal III.C.2: Complete the determination whether a petition meets the requirements of the Act no later than 120 days after the date a completed petition is filed with the RRHRP.

Context:

HRSA is currently developing regulations to determine the content and format of a full petition, the policies and procedures for submitting a full petition and the method for prioritizing payments, as required. Subsequent to the issuance of these regulations HRSA will call for petitions to be filed with the RRHRP. Timely, efficient resolution of claims is one of the primary objectives of the RRHRP. (Dependent upon completion of Program regulations).

Performance:

Performance standards are set forth in Section 103 (d) of the Act. The 120 day review period described in Section 103 (d) will begin upon receipt of a full petition containing all information as specified in the Program regulations.

Goal III.C.3: Subject to availability of sufficient amounts in the Fund, process payment of 90 percent of petitioner payment awards within 30 calendar days of approval of a completed petition.

Context:

HRSA is currently developing regulations to determine the content and format of a full petition, the policies and procedures for submitting a full petition and the method for prioritizing payments, as required. Subsequent to the issuance of these regulations HRSA will call for petitions to be filed with the RRHRP. Timely, efficient resolution of claims is one of the primary objectives of the RRHRP and prompt payment of petitioner payment awards contributes materially to its success. (Dependent upon completion of Program regulations)

Performance:

The target is set to process payment of 90 percent of payment awards within 30 days of approval of a completed petition. Performance standards were conceptualized, developed, and implemented following careful consideration by Program officials, in concert with OGC. Standards were, in part, based on requirements of the Prompt Payment Act and customary business practices in the private sector, with emphasis made on ensuring strict standards to satisfy the often urgent needs of the beneficiaries of this Program.